CLAIM AGAINST MURRAY CITY CORPORATION

INSTRUCTIONS

Please fill out the attached claim form completely. Missing information may delay the processing of your claim. Please type or print. Mail or hand-deliver the original claim form to:

Murray City Attorney's Office
5025 South State Street, Suite 106
Murray, Utah 84107

Copies or faxes are not accepted.

Your claim must include the following:

a. A detailed explanation of the incident including damages or injuries suffered. Where space is insufficient, use additional paper. Please make sure it can be easily read and understood with your Claim Form.
b. Exact location of incident.
c. Date and time of incident.
d. Claimant's name, address and phone number

Items helpful for the processing of your claim include:

a. Itemized receipts or estimates of damages.
b. Copy of Police Report, if applicable.
c. Copy of medical bills for personal injuries.
d. Pictures of the incident or damage and any other documentation that would help prove your claim. We cannot return documentation or photographs, or make copies for you. Please keep copies of any documents you send.

PROCEDURE

Claims must be filed with the Murray City Attorney within one (1) year from the action or incident. All questions regarding your claim should be directed to the City Attorney's Office at (801) 264-2640.

The City Attorney's Office requires sufficient time to complete an investigation of your claim. Compensation is paid only if Murray City is found liable. If compensation is paid, a Release of Claims will be required. It can take up to two weeks after the City receives a Release of Claims to process a check.

CLAIM AGAINST MURRAY CITY

Original **must** be returned by mail or in person to:
Murray City Attorney' Office, 5025 South State Street, Suite 106 Murray, Utah 84107

Name: (Please Print)	**Street Address:**	**Work Phone:**
Social Security or HICN #: (if personal injury)	**City, State, Zip:**	**Home Phone:**
Date and Time of Incident:	**Exact Location of Incident:**	**Mobile Phone/email address:**

Describe in detail all facts and circumstances of the incident. Please include names of all persons involved. Explain why you believe the City is responsible. Attach additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

Witnesses:

Did a law enforcement agency investigate? If yes, list agency and case no. Please provide a copy of the report. _____

Was a City employee involved? If yes, list name(s)/dept.: _____

Witness Name: _____ Address: _____ Phone: _____

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Witness Name: _____ Address: _____ Phone: _____

Damages: Itemized list of injuries and/or property damage claimed. Attach estimates/receipts. If personal injury, list bodily injuries, cost of medical treatment to date, and anticipated medical cost.

Amount Claimed

1. _____ **$**_____
2. _____ **$**_____
3. _____ **$**_____
4. _____ **$**_____

Total Amount $_____

Are you currently receiving Medicare? [ ] Yes [ ] No If yes, please fill out the Medicare Addendum.

Have you filed a claim with your insurance? [ ] Yes [ ] No If yes, please fill out the Insurance Information Addendum

Is your claim regarding a vehicle accident? [ ] Yes [ ] No If yes, please fill out the Vehicle Accident Addendum

I affirm and state that I have read the foregoing and that the same is true to the best of my knowledge, information and belief. I understand that filing a materially false statement may constitute fraud and subject me to criminal prosecution.

_____

Claimant's Signature

CLAIM AGAINST MURRAY CITY
MEDICARE ADDENDUM

Note: Effective January 1, 2010, the Medicare Secondary Payer Act (Federal Law) requires the City to report claims involving payments for bodily injury and/or medical treatments to Medicare.

Has any medical bill been paid or will any bill be paid by Medicare/Medicaid? **[ ]**Yes **[ ]**No. If yes, list Medicare/Medicaid number: _____

SSN or HICN# _____ Date of Birth _____

If the City is responsible for such bills, the City must report any settlement to Medicare/Medicaid.

Acknowledgment

I understand that the information requested is to assist the City to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligation under Medicare Secondary Payer Act 42 U.S.C§1395y.

_____
Medicare/Medicaid Beneficiary Name
(please print)

_____
Medicare/Medicaid Beneficiary Name Signature

CLAIM AGAINST MURRAY CITY

INSURANCE INFORMATION ADDENDUM

Insurance Coverage

Name of Insurer	
Policy Number	
Name of Agent	
Agent's Phone No.	
Mailing Address	
City/State/Zip	
What is your deductible?	
Were you paid by insurance?	

CLAIM AGAINST MURRAY CITY
VEHICLE ACCIDENT ADDENDUM

Claimant Name: _____
Date/Time/Location of Accident: _____

License Plate No.		Driver License No.		Auto (year/make/model)	

Vehicle Owner		**Driver (if not owner)**	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
Passenger(s)		**Passenger(s)**	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	

Insurance Coverage

Name of Insurer	
Policy Number	
Name of Agent	
Agent's Phone No.	
Mailing Address	
City/State/Zip	
What is deductible?	
Were you paid by insurance?	

Please diagram the accident in the box below. Please identify the names of the streets where the accident occurred, the nearest cross-streets and indicate where North is on your diagram.